



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS BACK INSTITUTE
PO BOX 262409
PLANO TX 75026-2409

Respondent Name

FEDERATED MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-0912-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Dr. Zigler, this patient was examined and saw the size of the fragment decided he was at an increased risk to develop cauda equine syndrome. This justified the emergency surgery. On 9/14/11 the adjuster and the case manager were notified of the emergency surgery the patient needed."

Amount in Dispute: \$3193.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges that reimbursement is owed because the surgical procedure was performed on an emergent basis. However, a review of the documentation and correspondence does not support Provider's assertion. First, the claimant underwent a surgical consultation on 9/13/11 and the procedure was scheduled for 9/15/11. If the procedure has been an emergency, the procedure would have been scheduled that day. Despite the two-day gap between the surgical consultation and the actual procedure, no request for pre-authorization, which was received on the day of surgery and likely reviewed after the surgery had already taken place was not authorized. Therefore, the reviewing physician did not think there was an emergency in this case, and in fact thought that the surgery was not even necessary. Finally, all correspondence from the Provider supports that this was an elective surgery, performed in order to avert a potential (but unrealized) emergency situation. Therefore, no emergency yet existed when the surgery was undertaken." "In summary, surgery was performed without pre-authorization. There was no emergency and the evidence shows that the procedure may not have been medically necessary. Therefore, no reimbursement is owed in this case."

Response Submitted by: Federated Mutual Insurance Co., Parker & Associates, L.L.C., 7600 Chevy Chase Dr., Suite 350, Austin, TX 78752

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2011	Professional Services – CPT Code 63710-59, 63030	\$3193.51	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
4. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 21, 2011

- 230-Treatment not authorized.
- 38-Services not provider or authorized by designated (Network/Primary Care) providers.
- 96-Non-covered charge(s).
- 9/15/11 Laminectomy L5-S1 was not authorized.

Explanation of benefits dated September 21, 2011

- 230-Treatment not authorized.
- 38-Services not provider or authorized by designated (Network/Primary Care) providers.
- 282-The insurance company is reducing or denying payment after reconsidering a bill.
- W1-Workers' Compensation jurisdictional fee schedule adjustment.
- The provider is requesting reconsideration and payment for the above charges we have reviewed the providers request, however, these charges continue to be denied per TX Rule 134.600, outpatient surgery must be pre-authorized. The provider may take this matter to DWC Medical Dispute Resolution for further disposition.

Explanation of benefits dated September 29, 2011

- 230-Treatment not authorized.
- 38-Services not provider or authorized by designated (Network/Primary Care) providers.
- 96-Non-covered charge(s).
- 9/15/11 Laminectomy L5-S1 was not authorized.

Explanation of benefits dated October 7, 2011

- 230-Treatment not authorized.
- 38-Services not provider or authorized by designated (Network/Primary Care) providers.
- 96-Non-covered charge(s).
- 9/15/11 Laminectomy L5-S1 was not authorized.

Issues

1. Did the disputed professional services, CPT codes 63710-59 and 63030 require preauthorization? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed professional surgical services, based upon "230-Treatment not authorized."

The requestor states in the position summary that "According to Dr. Zigler, this patient was examined and saw the size of the fragment decided he was at an increased risk to develop cauda equine syndrome. This justified the emergency surgery. On 9/14/11 the adjuster and the case manager were notified of the emergency surgery the patient needed."

28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

28 Texas Administrative Code §134.600(p)(2) states “Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.”

28 Texas Administrative Code §133.2 (3) defines “Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

- (i) placing the patient's health or bodily functions in serious jeopardy, or
- (ii) serious dysfunction of any body organ or part.”

The respondent states in the position summary that “The Provider alleges that reimbursement is owed because the surgical procedure was performed on an emergent basis. However, a review of the documentation and correspondence does not support Provider’s assertion. First, the claimant underwent a surgical consultation on 9/13/11 and the procedure was scheduled for 9/15/11. If the procedure has been an emergency, the procedure would have been scheduled that day. Despite the two-day gap between the surgical consultation and the actual procedure, no request for pre-authorization, which was received on the day of surgery and likely reviewed after the surgery had already taken place was not authorized.”

Review of the submitted documentation finds that the requestor did not submit documentation to support that the surgery performed on September 15, 2011 was on an emergency basis as defined in 28 Texas Administrative Code §133.2 (3) . Therefore, the disputed services required preauthorization per 28 Texas Administrative Code §134.600(p)(2). The requestor did not submit documentation to support preauthorization was obtained. As a result, the insurance carrier’s EOB denial of “230” is supported and no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		1/10/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.